Administrative MEDICAL CLAIM FORM Claim Ref:

Patient Name	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Card No	**: I022-029-114351406-01**
Policy Holder	**: MOHAMED SALIQ CHANELIPARAMBIL ABDUL KADER**
Payer Name	**: TAKAFUL EMARAT**
TPA	**: E CARE - Blue Network**
Validity	**: 28-03-2025** To **27-03-2026**
Gender	**: Male**
Date Of Birth	**: 23-Jan-1976**
Patient's Tel No	**: 0588878445**

Service Date **:13-Jun-2025** **Network** : Green

Health Provider **:CITICARE MEDICAL CENTER LLC** **Direct Access SP - YES**

Doctor's Name **:AISHA**

Co-Insurance :

CONSULTATION	LAB/RADIOLOGY	PHYSIO	PHARMACY	IP	MATERNITY	DENTAL
10% max	NIL	NIL	NIL LIMIT	NIL	10%	NA

Remarks :

☐ **Acute** ☐ **Pre-existing and chronic** ☐ **Maternity**

Chief Complaints : KNOWN DIABETIC CAME FOR BLOOD SUGAR LEVELS AND MEDICINE REFIL **Duration:**

Vitals:

Clinical Findings:

Diagnosis: E11.8 - Type 2 diabetes mellitus with unspecified complications, **Date of Onset** :13/47/2025

Requested Investigations: 80061, LIPID PANEL **Estimated Cost** :

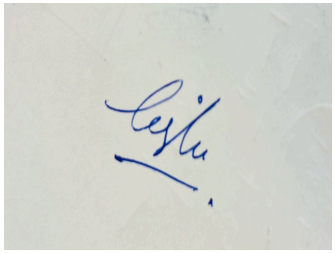
Prescriptions: **Estimated Cost** :

MEDICAL PRACTITIONER DECLARATION :

I declare that I am the patient's medical practitioner and that the particulars given are to the best of my knowledge true and correct.

Dr's Name : AISHA **Stamp :**

Dr. Aisha Umer
Physician- General Practitioner
DHA- 40131439-002
CITICARE MEDICAL CENTER
DUBAI - U.A.E

Signature :  **Date** : 13-Jun-2025

PATIENT'S DECLARATION :

I hereby authorize any Healthcare provider, Insurer, Employer or other organization to release any information regarding my medical condition & history for purpose of determining insurance benefits.

Patient 's signature{Parent : if minor} **Date :** 13-Jun-2025